Postgraduate medical training

Vocational training schemes, specialist registrar training programmes, and continuing professional development all require new thinking to meet the reasonable demands of elderly patients. The energy that has gone into defining the skills required of preregistration house officers has not yet been applied to those of us further on in our careers.[6] Postgraduate deans are silent on the matter. But why not require all general practitioners and hospital specialists (except the paediatricians) to have six months' experience in health care for elderly people? Mandatory attachments would not be sufficient to reduce the ageism and negativity of some doctors, but they would help many doctors to improve their history taking, examination, and management skills to a safe level.

A meeting in May 1999 on global perspectives in healthcare and clinical training, jointly organised by the Royal Colleges of Physicians and Surgeons, discussed topics as diverse as molecular medicine, hepatocellular carcinoma, and herbal medicine. Ageing was never mentioned. The blindness of our royal colleges, our medical schools, and our postgraduate deaneries must be challenged.

Globalisation of health care has resulted in doctors and nurses trained in one country seeking, and finding, work in another. The "needs based" undergraduate and postgraduate curriculums in developing countries do not include study of health care for older people. In many of these countries, substantially more doctors and nurses are trained than are required for local needs or can be afforded. The human resource potential currently lost to individuals and society might be captured by reorientation of our educational programmes and a deliberate policy of training for export. The potential for asset stripping of poorer countries to supply the needs of industrialised ones remains a dilemma.

Doctors, ourselves

We are all growing older, and if current employment patterns apply to medicine, many of us will need to consider second or even third careers. The traditional medical career from general practitioner principal or consultant from early 30s to retirement at 65 is likely to change dramatically. Increasingly, those who can are opting for early retirement, and all of us are at risk of redundancy in our early 50s. We have only just begun to think about the need for increasing the range of skills doctors possess throughout the course of their careers. However, much of continuing professional development does not consider new directions in medical and other careers but is conducted to ensure that we all get sufficient credits to maintain the status quo.

Ultimately, the narrow focus that dominates medicine from the undergraduate phase to the end our professional lives will be our undoing. We are guilty of providing a poor service to our elderly patients, and we will be doing ourselves a disservice in our own old age.

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A memorable patient

A surgical mishap

The German emperor Frederick III, though mortally ill, reigned briefly in 1888. He was popular ("Unser Fritz"), a liberal opposed to Chancellor Bismarck's "blood and iron" policies, and pro-British, being married to Queen Victoria's daughter Vicki. In 1887, while still crown prince, he developed symptoms of laryngeal disease. The German surgeons wanted to perform laryngectomy as they thought that cancer was certain, despite Rudolf Virchow—whose reputation remained high—not reporting pathological malignancy on the small specimen sent.

Victoria, however, sent across Morell Mackenzie, a leading ear, nose, and throat surgeon. He cast doubts on the diagnosis of malignancy and on the proposed surgery—perhaps he thought that it was syphilis, which was not uncommon among the upper classes at the time. When the diagnosis became incontrovertible it was too late for any surgery except a tracheostomy. The Germans blamed Mackenzie, who was ruined professionally, and Queen Victoria for the outcome. Frederick's militaristic son succeeded him as Kaiser Wilhelm II, and the rest is history. The received doctrine is that had the German diagnosis and treatment been acted on early a cured Frederick would have remained kaiser and the first world war would have been averted. But there was no reason to be certain of a successful result.

In 1943 Mr David Patey, consultant surgeon at the Middlesex Hospital and a brilliant teacher, passed on to a group of medical students, including myself, the following account as a warning against surgical arrogance. There were surgeons then at the Middlesex who could have served as models for Sir Lancelot Spratt. The story was told to him when he was a student in the early 1920s, by his surgical chief. "As a house surgeon, in about 1890, I went to Germany for a visit. I called at the local university hospital where I had an introduction to the professor of surgery, and was invited to watch an operating session. The first patient had carcinoma of the larynx. The professor looked at me, introduced me to the group, then announced, 'with this operation I would have saved the life of our beloved emperor.' I thought of slinking out in shame, but for the honour of England I stayed. The laryngectomy proceeded until there was a gush of arterial blood. Swabs were packed into the wound, the patient was hurriedly wheeled out, and no more was said of the incident nor of saving the emperor."

Mr Patey concluded that the moral was that you can never be sure of the results of major surgery, even on royalty.

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